FORM LF.009 2/99

CUMULATIVE HEALTH RECORD

STUDENT'S NAME _____ SEX _____ DATE OF BIRTH _____
LAST FIRST MIDDLE

PARENT OR GUARDIAN'S NAMES _____ ADDRESS _____

CODE: NO DEFECT O DEFECT X DEFECT CORRECTED (X) DEFECT BEING TREATED (T)

YEAR		19__	20__	20__	20__	20__	20__	20__	20__	20__	20__	20__	20__	20__
GRADE														
AGE														
HEIGHT														
WEIGHT														
VISION - RIGHT	FAR													
	NEAR													
VISION - LEFT	FAR													
	NEAR													
HEARING - RIGHT														
HEARING - LEFT														
DENTAL														
SCOLIOSIS	DEGREE PASS / FAIL													

ENTRANCE REQUIREMENTS

- ☐ EXAM BY PHYSICIAN OR NURSE PRACTITIONER
- ☐ IMMUNIZATION CURRENT
- ☐ BIRTH CERTIFICATE

To be completed by screening personnel

AREAS SCREENED	INITIAL SCREENING DATE SCREENED	Results P	Results F	RESCREENING	Results P	Results F	*Referral Recommendations
COMMUNICATION							
Speech (Articulation, Fluency)							
Voice (Quality, pitch, intensity)							
Language (Receptive/Expressive)							
MOTOR DEVELOPMENT							
Fine (perception, coordination)							
Gross (balance, coordination)							

* Failure of one or more areas after rescreening may require a referral to: (a) Child Study Committee (or similar) or (b) the director of special education for an evaluation.

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HEALTH SERVICES NOTES

YEAR		
19		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		

20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:
20		SIGNATURE:

IMMUNIZATION HISTORY

DOSE	DPT MO DAY YR	POLIO MO DAY YR	MEASLES MO DAY YR	RUBELLA MO DAY YR	MUMPS MO DAY YR	HEPATITIS B MO DAY YR	HAEMOPHILUS INFLUENZAE	Td ADULT MO DAY YR	VARICELLA MO DAY YR
1ST									
2ND									
3RD									
4TH									
5TH									